NOTICE

Competitive Request for Applications

Building a State-wide Infrastructure to Sustain a Coordinated School Health System in New Jersey

July 1, 2010 – June 30, 2011

Application Due Date: April 12, 2010

Issued By:

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February 2010

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COMPETITIVE REQUEST FOR APPLICATIONS (RFA) NOTICE

Building a State-wide Infrastructure to Sustain a Coordinated School Health (CSH) System in New Jersey

New Jersey Department of Health and Senior Services
Division of Family Health Services
Maternal, Child and Community Health Program
Child and Adolescent Health Unit

I. General Information

A. Statement of Purpose

The New Jersey Department of Health and Senior Services (DHSS), Child and Adolescent Health unit of the Maternal, Child and Community Health (MCCH) Program is announcing the availability of funds to build a sustainable state-wide infrastructure and implement activities using the Centers for Disease Control (CDC) Coordinated School Health (CSH) model. Successful applicants will be responsible for the administrative oversight, training, technical assistance and resource support for the implementation of CSH in at least eight (8) middle- and/or high schools of public school districts geographically located one each, in three New Jersey regions: Northern, Central or Southern. **School districts are a required partner for this application.**

School Health (SH) Specialists, hired by the successful applicant will collaborate with a School Health (SH) Coordinator identified by the school district partner. The SH Coordinator will ensure the implementation of required school health activities and assure that the activities, funded by this grant, align with State goals and project objectives. As a result of participation, the school district partner is expected to progressively expand the implementation of CSH district-wide. Collaboratively, the DHSS with its three successful applicants and their school district partners, will join the Department of Education's (DOE) New Jersey CSH Demonstration Project in serving as the proactive leaders to mobilize New Jersey's expansion of CSH statewide.

The goals for this pilot project are to increase the number of schools that are using CDC's CSH model to:

1) address the physical, emotional and social well-being of their students.

2) create opportunities for healthier choices by students and school staff through environmental or policy change strategies.

3) strengthen and sustain state and school district capacity to support a coordinated school health system through effective leadership, strategic partnerships, youth engagement, funding development and the use of data-driven and best practices or evidence-based programs.

As these goals are achieved, so too will be New Jersey's vision for "students to be healthy and ready to learn in a school environment that supports wellness and offers opportunities for healthy choices."

B. Background

The body of evidence demonstrating the relationship between health, education and academic achievement is recognized, strengthening and ever-growing. The National Association of State Boards of Education (NASBE) makes the case succinctly: "Health and success in school are interrelated. Schools can not achieve their primary mission of education if students and staff are not healthy and fit - physically, mentally and socially."

Most major public health organizations including the CDC as well as major health philanthropies such as The Robert Wood Johnson Foundation, now believe that policy and environmental change will prove to be the most effective strategies in combating obesity and its associated diseases. Health experts predict that if we fail to act now in creating the policy and environmental changes needed to support healthier lifestyle choices, it will be the first time in recorded public health history, that the current generation of youth will live shorter and sicker lives than their parent's generation.

Policy refers to the laws, regulations, rules, protocols, and procedures designed to guide or influence behavior. Policies can be legislative or organizational in nature. Environment refers to the physical, social, or economic spheres that influence people's practices and behaviors. Changes in policy or the environment have the potential to alter the choices that can benefit entire group of individuals rather than just one single individual. Applied to schools, policy and environmental change can help students, their parents and school staff engage in healthier behaviors, such as eating healthier foods and moving more every day, by making the healthy choice the easy choice as well as the one that is more available and more affordable.

The Surgeon General has identified tobacco use, overweight, physical activity and nutrition as the leading health risk indicators in the United States. Therefore, school strategies, particularly those focusing on environmental or policy changes that address the Surgeon General's health risk indicators, are a priority in this grant application.

The DHSS and other state department partners recognize the reality of providing the range of resources necessary for meeting student's physical, emotional, behavioral and social needs, extends well beyond the existing capacity of any single school district. Existing resources need to be effectively coordinated and leveraged. The buy-in and collaboration of numerous state-level departments and local-level groups ranging from the school district leadership, to school building administrators and staff, students and their families, to health department experts, community-based health and social service agencies, local businesses and others, is required.

Given this scenario, the grantor will function in a cooperative capacity with the grantee, being substantially more involved in the development, implementation and evaluation of activities than is usual in grants management. Appendix 1 describes grantor responsibilities related to this CSH pilot project. Emphasis will be on researching, identifying and recommending financial mechanisms for sustaining a CSH system. School health stakeholders will need to be diligent in collecting the documentation needed to influence policy makers and create public policy that establishes a comprehensive, sustainable and CSH system in New Jersey. Appendix 2 provides a current list of New Jersey CSH stakeholders.

The New Jersey DHSS and DOE with the Departments of Agriculture (NJDA), Transportation (DOT), Human Services (DHS) and Children and Families (DCF) have collaborated on a variety of inter-departmental school health issues from as early as the 1990s. In September of 2007, the NJDA led the State by creating the New Jersey Model School Nutrition Policy and requiring its

implementation by school districts. Policy implementation was preceded by NJDA sponsored workshops "Wellness Rules in New Jersey Schools" conducted in the spring of 2007. Two hundred eighty two (282) school districts were represented at these workshops at which time approximately one-third indicated that wellness communities were in place. By the end of September 2007, NJDA had received the name and contact information for the school district's designated wellness committee coordinator from 97% of all school districts participating in the federally-funded Child Nutrition Programs.

In March 2008 a five year CDC cooperative agreement was awarded to the DOE, in partnership with DHSS, to implement CSH. The CDC model uses a school health team, a self-assessment process, and an action plan that incorporates cross-discipline projects to focus on these areas of school health:

- Ensuring the **Health and Physical Education** curriculum is aligned with the New Jersey Core Curriculum Content Standards to be age-appropriate and comprehensive, motivating and engaging students to choose healthy behaviors that will last their lifetime;

- Offering school-based **Health, Counseling and Social Services** that promote student well-being by caring for their physical, emotional, behavioral and social needs through services that prevent, identify and treat health problems or injuries and/or makes referrals;

- Providing **Nutrition Services** that integrate and reinforce the nutrition education taught in the classroom with the food served in the school cafeteria;

- Supporting **Staff Wellness** through work-site activities that assess, educate and are accessible to all school staff for maintaining or improving their health and well-being;

- Creating a **Healthy School Environment** that fosters learning because it looks safe and feels supportive and is free of any conditions that pose a risk to the health of students and staff;

- Involving **Families and the Community** in advocating for resources, contributing their talents or helping to develop, communicate or implement programs and policies that support the health of the students, their families and the school community, at large.

In the Fall of 2008, the DOE conducted a New Jersey School Health Profiles (SHP) survey providing the baseline data for School-Level Impact Measures (SLIMs). SLIMs are the measures used by CDC to monitor the State's progress in the implementation of CSH. In December 2008, CSH state-level stakeholders discussed and selected six SLIMs – three for coordinated school health and one each for nutrition, physical activity and tobacco. The selected New Jersey SLIMs, the SHP survey results and the New Jersey 2012 targets are presented in Appendix 3.

This pilot project will be structured utilizing the CDC model. The successful applicant, in collaboration with the school district partner, will be required to create a school health (SH) Team. A SH Team has been identified as a best practice strategy in facilitating positive changes in the school environment and with school health programs and policies. The CSH SLIM #1 in Appendix 3 defines the composition of the Team. It is important that the SH Team be diverse enough to ensure that the assessment process, and its resulting action plan, includes the broadest perspective of input.

The first task of the SH Team is to analyze the strengths and weaknesses of existing school health policies, curricula, programs and services using CDC's self-assessment tool: The School Health Index (SHI). More information on this tool can be found at: www.cdc.gov/HealthyYouth. Using the results of the SHI assessment, the SH Team develops an action plan that prioritizes areas for improvement. For additional information and resources related to CSH, applicants are strongly encouraged to review and familiarize themselves with the "Web-site Resources" listed in Appendix 4.

C. The Needs of New Jersey Students

Tobacco is the leading cause of preventable death and disability in the United States. Approximately 90 percent of adult smokers started smoking before the age of 18 and young people who live with a smoker, are twice as likely to become smokers themselves. Nearly 20,000 New Jersey teens become regular smokers each year and almost 400,000 young people in New Jersey are exposed to secondhand smoke at home. Results of the 2007 New Jersey Student Health Survey conducted with high school students, indicated that about two-thirds (68%) of high school students believed that smoking a pack of cigarettes per day was a great health risk. Although reports of lifetime and recent cigarette use among students continues to decline, the percentage of students who reported being daily smokers was slightly up from 4% in 2005 to 5% in 2007.

After smoking, excess weight is the second leading cause of death and New Jersey is no exception to the childhood obesity public health epidemic that plagues our country. A retrospective survey of 2,393 sixth grade health records from 40 randomly selected public schools of varying socio-economic strata was conducted during the 2003-2004 school year by DHSS in collaboration with DOE. The survey indicated that 38% of youth were either obese (20%) or overweight (18%). African-American and Latino youth were more likely to be overweight than white youths. (NJDHSS. "Childhood Weight Status, New Jersey 2003-2004").

The 2007 Student Health Survey indicated that among high school students:

- 53% were either obese (21%) or overweight (32%) using BMI percentiles;
- 57% watched TV, played video games or were on the Internet for three hours or more than three hours in front of a screen on the average school day including 31% who did so for five or more hours;
- approximately two-thirds of students engaged in vigorous exercise for 20 or more minutes on three or more days per week in the past week remaining relatively constant since 2005. However, students who had been physically active for at least 60 minutes five or more days dropped from 34% (2005) to 31%;
- only 9% reported drinking three or more glasses of milk per day and only 19% ate five or more servings of fruits and vegetables per day during the past week.

The overweight youth is at risk for high blood pressure and high cholesterol levels. This increases their risk for chronic disease including heart disease, certain types of cancer and Type II diabetes. Other physical problems may include arthritic and orthopedic problems, sleep apnea and asthma. Common psycho-social issues include depression, being a victim of bullying and/or poorer academic performance. Students faced with these issues are more prone to absenteeism, or when in school, may experience problems with their attention span or struggle with other learning challenges.

Current research in youth protective factors has shown that students are more likely to engage in healthy behaviors when they feel connection… to their parents, their family, a religion, or their school. Of these protective factors, school connectedness was found to be the strongest factor, for both boys and girls, in decreasing substance use, school absenteeism, early sexual initiation, violence, and the risk of unintentional injury (for example drinking and driving or not wearing seat belts). In regards to issues of emotional distress, disordered eating and suicide ideation or attempts, school was second only to family as a protective factor.

A strong relationship between school connectedness and student achievement, including school attendance, staying in school longer, higher grades and classroom test scores has also been demonstrated. In turn, students with higher grades were found to be significantly less likely to engage in risky behaviors such as carrying a weapon, smoking cigarettes, drinking alcohol or having sex. (CDC. "School Connectedness: Strategies for Increasing Protective Factors Among Youth"; 2009)

D. Project Outcomes

The outcomes of working collaboratively to build a state-wide infrastructure for sustaining a CSH system and implement policy and environmental changes that will increase opportunities for engaging in physical activity, making healthier food choices and reducing tobacco use are to:

1) improve the health (physical, mental and social), safety and well-being of students and school staff.

2) increase graduation rates by reducing absenteeism and drop out rates and thus improving academic performance.

Ultimately, the investment in student health and education TODAY will reap the benefits for future economic success TOMMORROW, for both the student and the state of New Jersey.

II. Policies and Requirements

A. Eligibility

Eligible applicants must be New Jersey-based:

- public agencies such as: county-serving health departments, Governmental Public Health Partnerships (GPHPs), institutions of higher education and school districts or other public entities having the capacity to conduct the project as described;

- private non-profit health, social service or educational organizations; institutions of higher education, hospital healthcare systems or other community-based entity having the capacity to conduct the project as described. A tax determination letter or other proof of non-profit status is required.

Eligible applicants are required to have an established history of working with middle- and/or high schools and must be capable of hiring for the position of SH Specialist within 60 days of the grant start date. Eligible applicants are strongly encouraged to partner with Rutgers Cooperative Extension by contacting the Family and Community Health Sciences faculty/staff at their county office.

B. Targeted School Population

Grant funds will be used to assist the DHSS in conducting a pilot project to implement the CDC CSH model in at least eight public middle- and/or high- schools of public school districts geographically located one each in three New Jersey regions. Using the school district code, an eligible applicant is limited to selecting no more than four schools in any one district. For the purposes of this RFA, a middle school is defined as a school that terminates in the 7th through 9th grade.

The DHSS will fund one applicant agency in each of three New Jersey regions:

1) Northern: Bergen, Essex, Hudson, Morris, Passaic, Sussex and Warren counties.

2) Central: Hunterdon, Mercer, Middlesex, Monmouth, Somerset and Union counties.

3) Southern: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean and Salem counties.

The applicant agency is required to have one school district partner that serves a disparate student population. For the purposes of this application, a disparate student population is defined as**:**

- being located in one of the cities in the following counties:

  Atlantic - Atlantic City
  Camden - Camden City
  Cumberland - Vineland
  Essex - East Orange, Irvington, Newark
  Hudson - Jersey City, North Bergen, Union City
  Mercer - Trenton
  Middlesex - New Brunswick, Perth Amboy
  Monmouth - Asbury Park
  Ocean - Lakewood
  Passaic – Paterson, Passaic

  OR

- having more than 50% of the student population eligible for free and reduced school lunch meals.

C. Funding Information

A total of up to $930,000 will be available to fund three health service grants, one each in the Northern, Central and Southern New Jersey region, in amounts ranging from $290,000 - $330,000 per grant.

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Funds are provided from the federal Maternal and Child Health (MCH) Block Grant and the Preventive Health and Health Services (PHHS) Block Grant. All grant awards are contingent upon the continued receipt of these funds by the DHSS.

It is the intent of this grant to provide funds for a three (3) year pilot project period. However, budgets will be annually submitted and approved for the periods of:

Year 1 - July 1, 2010 through June 30, 2011
Year 2 - July 1, 2011 through June 30, 2012
Year 3 - July 1, 2012 through June 30, 2013

Grant funds can be used for the following costs:

- Personnel: salary and fringe benefits for two full-time equivalent (FTE) SH Specialists; supervision of the SH Specialists;

- Consultant: pro-rated audit services;

- Office Expenses: office supplies, printing, postage, telephone, computer and related data processing supplies;

- Program Expenses: Fitnessgram licenses and software for the school district partners is a required purchase. More information about the Fitnessgram is available on the website: http://www.fitnessgram.net or by contacting Angie Fiala, K-12 sales manager at Human Kinetics Inc. by phone: 217-403-7997 or email: angief@hkusa.com. Fitnessgram training will be offered to successful applicants. Also, youth incentives, meeting supplies, educational materials.

- Training and continuing education programs or meetings for the professional development of the SH Specialists on topics related to this CSH pilot project;

- Travel: work-related mileage reimbursement;

- Equipment: Lap top;

- Facility Costs;

- Sub-grants: a memorandum of agreement (MOA) with each school district partner, in the amount of $10,000 per school, to support the costs of providing:

    1) a stipend to the SH Coordinator.

    2) program expenses associated with implementing 2 or more school health actions per school per grant year.

    3) educational or meeting supplies for the SH Team, Youth Advisory Council (YAC) and one youth and adult focus group each; and, youth incentives.

    4) trainings and continuing education programs or meetings for the professional development of the SH Coordinator on topics related to the CSH pilot project.

- Indirect costs, **only** with the submission of a third party government letter of approval justifying these costs.

Grant funds **may not** be used for over-night accommodations in New Jersey, New York City or the City of Philadelphia or for association or organization memberships. Ineligible costs will be removed. Grant funds can not be used to supplant existing sources of funds.

In addition to grant funding, other benefits to be gained by participating in this pilot project include:

1) training and technical assistance on such topics as effective school health and wellness teams, best practices, community partnerships and collaborations, policy development, effective success stories.

2) access to state, federal and national resources including recognized and evidence-based health and physical education curriculum assessment tools.

3) statewide recognition of accomplishments.

4) participation in the review and/or development of state and local policy(ies) and practices.

5) development of statewide collegial network of professionals, bound by a common vision for students to be healthy and successful now and as our future generation of adults.

There is no minimum matching funds requirement for this grant application. However, the degree of local commitment given to this application will be assessed in the scoring of applications and is described in the "Budget" section of this RFA and Appendix 5 "Scoring Criteria and Points."

D. Applicant Agency Grant Requirements

Two SH Specialists will be hired by the applicant agency to provide the oversight, technical assistance, training and resource support needed by the school district partners. The SH Specialists shall be hired within 60 days of the grant start date. The SH Specialists will function as the liaisons between the State staff and the school district partners. The SH Coordinator will be the contact person at the school district who will work collaboratively with the SH Specialists. The applicant agency will ensure that the school district partners are completing their grant required activities and working toward meeting the NJ identified SLIMs. The applicant agency, in collaboration with the school district partners, is required to submit a School Health Action Plan (SHAP) that identifies the pilot project goals, measurable objectives, methods/action steps and evaluation (evidence of success) for year one (1). See Attachment 2 for the template to be used for the SHAP. Grantee responsibilities and required activities for the SH Specialist position are described in Appendix 6.

E. School District Partner Requirements

The SH Coordinator is required to meet with SH Specialists within one month of hire by the applicant agency. The SH Coordinator is responsible for facilitating, coordinating and implementing required activities at the participating middle and/or high school(s). The responsibilities and required activities of the school district partner are described in Appendix 7.

F. Evaluation

Evaluation indicators to be used for this CSH pilot project include the New Jersey identified SLIMS (Appendix 3), seven required performance indicators or other data indicators as the school district may determine, in collaboration with the applicant agency. The school district partners of the successful applicant agency will be required to participate in the School Health Profiles Survey, conducted by the DOE as well as in technical assistance and/or training provided by the DHSS and/or one of its partners.

Quarterly progress reports are required for submission by the grantee in consultation with the school district partner. These reports will summarize the status or accomplishment of grant required activities and issues including barriers encountered; opportunities that emerged; and/or lessons learned. The grantee and its partners are also required to participate in an annual site visit that will be conducted by the grantor.

G. Termination of Grant

The DHSS reserves the right to terminate an approved grant based on any one of the following criteria:

1) unsatisfactory performance in meeting grant requirements by either the grantee or the school district partner.

2) inability to increasingly leverage school district and/or community partner in-kind services and/or resource contributions or identify new, additional funding sources in subsequent funding years.

3) chronic (2 or more) late submissions of quarterly progress or expenditure reports per grant year.

4) unavailability of funds.

III. Application Process

A. Required Components

1. Abstract

On a separate attachment titled “Abstract – Coordinated School Health in (names of school districts)”, complete a one page at-a-glance summary that includes the following information:

a) Name of applicant agency, name of contact individual with email address and phone number.
b) Name of school district partners.
c) Name of community partner organization(s).
d) Grant goals and objectives.

2. Application for Grant Funds

The DHSS is in the process of implementing SAGE - System to Administer Grants Electronically. The Application for Grant Funds, in response to this RFA, is required to be processed through SAGE. Applicants MUST register with a USERNAME and Password at the NJDHSS SAGE System Homepage located at SAGE.NJ.GOV after attendance at a mandatory State-conducted SAGE training.

ALL applicants and their designated program and financial personnel are required to register and attend this mandated SAGE training to be scheduled in the very near future. The SAGE training will acquaint applicants with the aspects of the automated system that are critical to the successful submission of the application. This includes the registration process, State links to the Department grant applications and the system shut down based on the application deadline. More details will be provided at the TA meeting.

The Application for Grant Funds consists of:

Page 1, FS 40.

Page 2, The Statement of Local Governmental Public Health Partnership.

Page 3, Assessment of Need(s). A "need" is defined as the difference between the current status and the outcome(s) that the school district partner would like to see achieved. Each school district partner shall describe the demographic, socio-economic, academic, physical and mental health characteristics of their student population using current (within three years) and available data sources. This section justifies the need for the CSH pilot project in the school district.

Appendix 8 lists a range of available data sources for locating school data based on the characteristics or behaviors to be addressed in the student population. This RFA requires that the applicant and its school district partners select at least three (3) of the following performance indicators:

- Number (#) and Type of Conduct Referrals
- # and Reasons for Detentions
- Rate of Average Daily Attendance
- Truancy*
- # Graduates
- # Failures
- Changes in Student Knowledge
- Changes in School Conditions
- # and Reasons for In- and Out-of School Suspensions
- # Unexcused Absences
- Tardiness
- Juvenile Arrests
- # Dropouts
- # Retentions
- Changes in Student Health Status
- Changes in School Health Policy

*Truancy: 10 or more cumulative unexcused absences, as the term "unexcused absence" is defined by the district board of education, pursuant to N.J.A.C. 6A: 16-7.8(a)3, consistent with the definition of a school day, pursuant to N.J.A.C. 6A:32-8.3.

The data presented in the "Assessment of Need(s)" narrative requires citation by source and year. The "Assessment of Need(s)" narrative has a 2 page limit per school district partner. This section has a score value of up to 15 points.

Attachment 1, Resource Directory of Youth-serving Health and Social Service Agencies. The applicant agency and its school district partners are required to identify and list the agencies and organizations available to their student population using this attachment. The Resource Directory can be used by CSH stakeholders to identify existing service gaps and overlaps. Youth can use the Resource Directory to create a student-friendly version for locating needed health and social services. The School District Partner's SH Coordinator is required to review the Resource Directory with the SH Specialists annually and update as needed. The Resource Directory has a score value of up to 4 points.

Page 3, Objective(s) and **page 4 Method(s) and Evaluation of Project.** Type "see **Attachment 2: School Health Action Plan (SHAP)**". The SHAP has a score value of up to 18 points.

The applicant agency, collaborating with the school district partners shall develop, implement and evaluate a SHAP that encompasses the objectives and activities to be accomplished. The SHAP consists of these elements:

Goal(s)	The school district goals for CSH shall support the goals identified in the "Statement of Purpose" of this RFA.
Objectives	Refer to Appendix 9 for "Writing Measurable Objectives" Objectives shall address the performance indicators identified by the applicant and its school district partners. Process measures, indicating whether the project is going as planned, shall also be identified and address the: ● number of programs/services to be provided ● number of student participants to be educated. ● systems changes (e.g. new school health policies new funding strategies or new practices) that are expected to occur as a result of the pilot project.
Methods	These are the activities, actions, programs, services or interventions that will take place to achieve the objective. When relevant, methods shall consider these criteria: • proven "effective" or published as "best practices" or "model" programs; • age, gender and culturally sensitive in addressing the needs of the student population; • involving family and/or significant adults involved in the students' life; • engaging students to obtain their input in creating and modifying CSH activities at their school.
Evaluation Tools and Indicator(s)	The data or information to be collected and used to evaluate what activities have occurred and if the change expected, as a result of initiating CSH, was achieved.

For the purposes of this pilot project, the performance indicators that will be used are the:

1) New Jersey identified SLIMS (Appendix 3).
2) 3 grantee/school partner selected performance indicators.
3) other data indicators as determined by the school district partners in collaboration with the applicant agency.

In addition to grant required CSH activities, the SHAP shall also address:

- work activities of the SH Specialist during the school district's summer, winter, and spring breaks;

- sustainability strategies that may include the leveraging of current funding sources or identifying new funding sources (pilot project years 2 and 3);

- promotional strategies to be used for CSH with students, families and the community at-large (pilot project years 2 and 3).

Page 5, Cost Summary and Schedules A, B and C pertain to the "Budget" section of this application. This section has a score value of up to 5 points based on the submission of a realistic and accurate line item budget with appropriate justification of the costs for accomplishing the grant objectives and requirements.

Page 6, Funds and Program Income From Other Sources… documents the degree of local commitment given to this application. There is no minimum matching fund requirement for this grant pilot project. However, the contributions identified on page 6 will be assessed in the scoring of applications.

The value assigned to the contribution of resources and/or in-kind services shall be indicated on the signed LOSs from the school district and community partners. The applicant agency may also contribute resources and/or in-kind services but the value of this contribution can not exceed the combined value of the school district and community partner contributions. The contribution of resources and/or services can include, but are not limited to:

- in-kind staff to conduct educational presentations or trainings
- student incentives, educational materials
- office supplies or equipment
- use of facility space
- expertise: public relations, marketing, technology
- data collection, analysis or evaluation services
- providing referral, mental health counseling or social services
- fundraising
- cash contributions
- other, identify:_____

The contribution of resources and/or services documented by the applicant agency, school district and community partners is calculated as a **percentage of the proposed budget amount requested from the state,** not the total budget.

The point value allocated is based on the percentage of in-kind contributions as follows:

Per Cent (%)	Points
< 2……..	……2
2.1- 4.0	……4
4.1 – 5.5	……..6
5.6 – 6.9	8
≥ 7	……10

The inability of the applicant agency to increasingly leverage school district and community partner contributions or identify additional funding sources for years 2 and 3 may jeopardize the continuation of grant funding.

Attachment 3, Letter of Support (LOS) – Required School District Partner. The applicant agency is required to submit this attachment for each school and it shall be signed by both the school district's Superintendent and the school building Principal. The dollar value of any contributions made by the school district partner is to be documented on the LOS as well as on page 6 "Funds and Program Income from Other Sources…."

Attachment 4, Letter of Support (LOS) - Community Partner. The applicant agency must submit this attachment from each organization that recognizes the need for a comprehensive and coordinated school health system and will support the applicant agency and it's school district partners by committing services and/or resources during the grant pilot project period. The dollar value of the organization's contributions is to be documented on the LOS as well as on page 6 "Funds and Program Income from Other Sources…". There is a point value of up to 15 points for community collaboration.

Schedules D, G, H, I, J and K shall be completed in accordance with the application instructions.

3. Additional application components:

a. Applicant Agency Capacity and Collaboration. This attachment shall not to exceed 5 pages and has a score value of up to 18 points.

This attachment shall describe the applicant agency's commitment, leadership experience and accomplishments specific to establishing and sustaining partnerships and collaborative activities with schools and/or community-based organizations. What strengths and organizational resources justify the selection of the applicant agency as the best candidate for this pilot project?

The description should specifically address the planning, promoting, implementation and evaluation of projects that demonstrate the applicant's capacity to meet the requirements of this RFA. What were the outcomes achieved in those projects? What worked and/or what lessons were learned that could be applied to ensure the success of this pilot project?

A copy of the applicant agency's organization chart is required and the supervision of the SH Specialist delineated.

The applicant agency shall submit a resume(s) of the potential candidate(s) for the SH Specialist positions, if known.

b. School district (name) Capacity and Collaboration. This application component shall not to exceed 3 pages per school district and has a score value of up to15 points.

This attachment shall describe the extent to which activities, practices and/or policies are **currently in place,** at each school district, for each component of CDC's eight component model using this numerical scale: 1 = nothing in place
2 = something in place
3 = everything known is in place

For responses 2 and 3, briefly support the response. School district partners that have conducted an assessment, using either CDC's SHI or the Alliance for a Healthier Generation's (AHG) Healthy Schools Inventory, shall indicate the process used and the school health priorities that were identified.

The most effective CSH system is the one in which there is a direct line of supervision from the Superintendent's office to the SH Coordinator. The organization chart for each school district partner should clearly indicate the position responsible for the supervision of the SH Coordinator.

The school district partner shall submit the resume of the potential candidate for the SH Coordinator position, if known.

The school district partner is required to provide the applicant agency with a copy of their Board of Education's (BOE) approved School Wellness/Nutrition Policy for submission with the application.

c. As applicable to the time frame of the grant year, submit:

- salary plan for merit or cost of living increases
- fringe benefit justification
- consultant agreements
- travel policy
- indirect cost agreement indicating cognizant agency negotiated rate
- rental /lease agreements
- Method of Payment request form
- Attachment C

Upon receipt of the "Notice of Grant Award" (NOGA), the approved applicant shall create a Memorandum of Agreement (MOAs) will be required for the transfer of funds from the applicant agency to the school district partner and to ensure the accountability of the agreed upon responsibilities between the applicant agency and the school district partner.

B. Mandatory Technical Assistance Meeting

Applicant agencies are **required to attend the technical assistance meeting** to be eligible to submit an application. This meeting is scheduled for:

Date:	February 23, 2010
Check-in Time:	12:30 – 1:00 pm
Meeting Time:	1:00 – 4:00 pm
Location:	NJ State Police NJ Forensic Science Technology Center 1200 Negron Drive Hamilton, New Jersey 08691
Phone:	(609) 584-5051 Ext: 5490

This technical assistance meeting will provide the opportunity for potential applicants to review, clarify and ask questions about the information presented in this RFA. No further technical assistance on the RFA will be provided after this training.

On-line registration is required to attend this mandatory technical assistance meeting through the New Jersey Learning Management Network at: https://njlmn.rutgers.edu, no later than 12:00 noon on February 22, 2010. Registration will be limited to five representatives per applicant agency.

C. Application Submission

The DHSS administers discretionary grant programs in strict conformance with procedures designed to ensure accountability and integrity in the use of public funds. An applicant agency will lose the opportunity to be considered eligible for a grant award if the application is not submitted by the deadline. The automated SAGE process shuts down application submissions at the deadline.

Use complete sentences in the narrative sections and adhere to page limits. Reviewers will be instructed to disregard content exceeding the page limit.

Without exception, applications must be submitted no later than 11:59 p.m. on April 12, 2010. SAGE promptly shuts down the application process at midnight on April 13, 2010.

D. Application Review Process

The DHSS reserves the right to reject any application not in conformance with the requirements of this RFA. “Complete” applications will undergo a review committee process.

The review committee will assess and score each application according to Appendix 5: Scoring Criteria and Points. An application must score ≥ 75 points to be approved for funding. Applications meeting these criteria will be rank ordered from the highest to the lowest score.

E. Grant Award Process

Grants will be awarded, in rank order, up to the limits of available funds. The DHSS will fund one successful applicant each in the North, Central and Southern geographic regions of the State with a disparate student population.

Applications with scores of ≥75 points, but for which grant funds are not available, will be approved as ”eligible for funding”, should future funds become available.

F. Notification of Grant Award

It is anticipated that applicants will be notified of the award status (acceptance or rejection) on or around May 28, 2010. At this time, the DHSS staff may need to schedule a meeting with the grantee to negotiate and finalize the budget.

Funding and issuance of a grant is contingent upon the availability of funds.

G. 2010 RFA Timelines

February 8……Release of RFA
February 22… Deadline to pre-register on the New Jersey Learning Management Network
12 noon for mandatory technical assistance meeting
February 23.....Mandatory technical assistance meeting
April 12……. Application deadline (no later than 4 pm)
May 28……..Notification of grant award
July 1…….. .Grant year begins

Attachment 1

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY

Resource Directory of Youth-serving Health and Social Service Agencies

Serving: _____ Area

Program Name and Location	Type of Service(s)	Contact (phone/web site)

Attachment 2

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
School Health Action Plan (SHAP)

Applicant Agency: **Date:**
GOAL #

Date To Be Completed By	Measurable OBJECTIVES	METHODS (Action Steps)	EVALU

Attachment 3

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
Letter of Support-Required School District Partner

July 1, 2010 – June 30, 2011

Complete, sign and submit this form with the application as evidence of the school's support to collaborate on the implementation of a Coordinated School Health system.

Name of Applicant Agency_____

Name of School_____

Contact Name and Title_____

Phone # _____ E-mail _____

It is my understanding that, if this application is approved for funding, the applicant agency will develop a MOA to provide $10,000 to the school district to support the costs of implementing the required grant activities. Additionally, the applicant agency will provide training, technical assistance and resource support to the SH Coordinator and SH Team. The SH Coordinator will collaborate with the applicant agency to ensure that:

- required grant activities are completed
- a funding sustainability plan for CSH is reviewed annually and revised as needed
- marketing efforts are made to promote CSH with students, their families and the community
- requested non-confidential data is provided to the applicant agency for evaluation purposes
- efforts to pilot CSH is supported and subsequently expanded district-wide
- resource contributions for project years two and three are documented on the renewal application

Check services/resources to be contributed by School District Partner

__ In-kind staff to conduct school employee, parents and/or student education	__Provide referral, mental health counseling or social services
__ Office supplies or equipment	__Data collection, analysis or evaluation services
__ Educational materials	__Expertise: public relations or marketing/ technology
__ Youth incentives	__Fundraising
__ Use of facility space	__Cash contribution
	__Other (specify)_____

The dollar value of these services/resources is estimated to be $_____.

_____ _____
Print Name - School District Superintendent Signature - School District Superintendent

_____ _____
Print Name – Middle School Principal Signature – Middle School Principal

_____ _____
Print Name - Applicant Administrator/ CEO Signature - Applicant

Date_____

Attachment 4

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
Letter of Support-Community Partner

July 1, 2010 – June 30, 2011

Complete, sign and submit this form for each community partner with the application to document commitment to the implementation of a Coordinated School Health system.

Applicant Agency Name_____

Name of Community Partner_____

Contact Person Name and Title_____

Address_____

Telephone #_____E-mail_____

Check type of organization:

__Hospital, FQHC, other Health Care organization __City Government __Social Service/Mental Health __Parent Teacher Organization __Law Enforcement __Business/Corporation __Community-Based Organization	__Faith-based Organization __Voluntary Health Organization __Civic or Service Association __YMCA __Department of Parks & Recreation __Municipal government: Mayors Wellness Campaign __Senior Centers

Check services/resources to be contributed by Community Partner

__ In-kind staff to conduct school employee, parents and/or student education __ Office supplies or equipment __ Educational materials __ Youth incentives __ Use of facility space	__Provide referral, mental health counseling or social services __Data collection, analysis or evaluation services __Expertise: public relations or marketing/ technology __Fundraising __Cash contribution __Other (specify)_____

As a Community Partner who recognizes the need for a comprehensive and coordinated school health system, my organization will act in full partnership to support the applicant agency by committing services and/or resources indicated above, as agreed upon, during the grant project period.

The dollar value of these services/resources is estimated to be $_____.

I understand that the applicant agency is documenting the dollar value of these services/resources on the form "Funds and Program Income from Other Sources Related to this Application."

_____ _____
Print Name - Community Partner Administrator/CEO Signature - Community Partner Administrator/CEO

_____ _____
Print Name – Applicant Administrator/CEO Signature – Applicant Administrator/CEO

_____
Date

Appendix 1

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
Grantor Responsibilities

State-level CSH staff will be involved in the project's activities, beyond routine grant monitoring. State CSH staff will work in collaboration with other state departments and public/private entities to accomplish activities, as needed and appropriate.

State CSH activities include:

1) Providing technical assistance, guidance, and coordination to ensure program success.

2) Providing public health information, trainings, and technical assistance related to program planning, implementation, surveillance, professional development, and evaluation; and dissemination of proven principles for prevention, evidence-based and successful strategies.

3) Reviewing current science and practice to ensure that guidance up-to-date knowledge relative to improving school health programs, promoting health and wellness, and reducing health risk behaviors, particularly among youth at high risk for health disparities.

4) Collaborating with other state departments as well as nongovernmental organizations (NGO) in planning and carrying out state strategies to improve school health programs and prevent or address important health risk behaviors.

5) Collaborating with school health stakeholders to develop policy recommendations and implement relevant and appropriate interventions.

6) Organizing and convening meetings of state and local organizations to strengthen efforts that promote school health and prevent risk behaviors and integrate these into existing school health efforts.

7) Providing opportunities for involvement at state conferences and local meetings or trainings.

8) Advising funded partners on documentation for measuring the outcomes and impact of school health policies and programs at the school level and preparing success stories.

9) Providing guidance to Professional Development (PD) recipients in jointly planning and delivering PD opportunities for colleagues, school staff and the local community.

10) Providing input and guidance in the selection of key personnel funded through this cooperative agreement.

11) Providing guidance and recommendations for program modifications through site visits, reporting and other strategies.

Appendix 2

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
New Jersey Stakeholders

State Departments

Agriculture (NJDA)
- NJ Healthy Schools Program

Children and Families (DCF):
- School Based Youth Service Programs (SBYSP)

Education (DOE)
- Office of Program Support Services
- Office of Student Support Services

Environmental Protection (DEP)

Health and Senior Services (DHSS):
- Comprehensive Tobacco Control Program
- Maternal, Child and Community Health (MCCH) - Child and Adolescent Health unit
- Office on Nutrition and Fitness
- Office on Public Health Infrastructure (OPHI)
- WIC Services

Juvenile Justice Commission (JJC)

Transportation (DOT)
- Safe Routes to Schools

Higher Education

Montclair State University, Department of Health and Nutrition Sciences
Rutgers University: Department of Family & Community Health Science
Rutgers Cooperative Extension – RCE of Hunterdon County;
NJ SNAP-ED Support Network

Foundations

Mountainside Health Foundation – Team Health
Robert Wood Johnson Foundation (RWJF)
- Alliance for a Healthier Generation (AHG)

Health Care/Medical/Health Insurers

Amerigroup Community Care
AtlantiCare-Center for Community Health
Horizon NJ Health

Professional Organizations

American Academy of Pediatrics
NJ Association of Health and Physical Education, Recreation, and Dance (AHPERD)
NJ Council of Children's Hospitals
NJ State School Nurses Association
NJ Health Care Quality Institute

Not for Profit Organizations

Princeton Center for Leadership Training
The NJ Health Care Quality Institute
The Pediatric/Adult Asthma Coalition of NJ
New Jersey PTA

Appendix 3

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
School Level Impact Measures (SLIMs)

Coordinated School Health
and
Physical Activity, Nutrition, and Tobacco-use (PANT) Prevention

New Jersey results were obtained from School Health Profiles (SHP) Survey conducted by the Department of Education (DOE) in the Fall of 2008. The NJ targets were established by consensus for the CSH cooperative agreement with CDC and are the expected outcomes when the SHP Survey is conducted in the Fall of 2012.

Coordinated School Health SLIMs
The percentage of schools that have a group (e.g., school health team) that helps plan and implement school health programs, with representation from 10 or more of the following:

- School administration
- Health education teachers
- Physical education teachers
- Mental health or social services staff
- Nutrition or food service staff
- Health services staff (e.g., school nurse)
- Maintenance and transportation staff
- Students
- Parents or families of students
- Community members
- Local health departments, agencies, or organizations
- Faith-based organizations
- Businesses
- Local government

NJ Baseline Fall 2008 = 12%
2012 Target = 17%

The percentage of schools that have ever assessed their policies, activities, and programs by using the School Health Index or a similar self-assessment tool in any of the following areas:

- Physical activity
- Nutrition
- Tobacco-use prevention

NJ Baseline Fall 2008 = 40%
2012 Target = 50%

The percentage of schools in which students' family or community members have helped develop, communicate information about, or implement policies and programs on any of the following health issues:

- Tobacco-use prevention
- Physical activity
- Nutrition and healthy eating

NJ Baseline Fall 2008= 56%
2012 Target = 66%

Physical Activity/Education SLIM
The percentage of schools that teach about all of the following in a required course:

- Physical, psychological, or social benefits of physical activity
- Health-related fitness (i.e. cardio-respiratory endurance, muscular endurance, muscular strength, flexibility, and body composition)
- Phases of a workout (i.e., warm-up, workout, cool down)
- How much physical activity is enough (i.e., determining frequency, intensity, time, and type of physical activity)
- Developing an individualized physical activity plan
- Monitoring progress toward reaching goals in an individualized physical activity plan
- Overcoming barriers to physical activity
- Decreasing sedentary activities such as television viewing
- Opportunities for physical activity in the community
- Preventing injury during physical activity
- Weather-related safety (e.g., avoiding heat stroke, hypothermia, and sunburn while physically active)
- Dangers of using performance-enhancing drugs such as steroids

NJ Baseline Fall 2008 = 61%
2012 Target = 73%

Nutrition SLIM
The percentage of schools that use at least three of the following strategies anywhere in the school to promote healthy eating:

- Price nutritious food and beverage choices at a lower cost while increasing the price of less nutritious foods and beverages
- Collect suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating
- Provide information on the nutrition and caloric content of foods available
- Conduct taste tests to determine food preferences for nutritious items
- Provide opportunities for students to visit the cafeteria to learn about food safety, food preparation, or other nutrition-related topics

NJ Baseline Fall 2008 = 34%
2012 Target = 39%

Tobacco Use Prevention SLIM
The percentage of schools that implement a tobacco-use prevention policy in all of the following ways:

- Provide visible signage.
- Communicate the policy to students, staff, and visitors.
- Designate an individual responsible for enforcement.
- Have a process in place for addressing violations.
- Use remedial rather than punitive sanctions for violators.
- Tailor consequences to the severity and frequency of the violation.
- Communicate student violations to their parents and families.

NJ Baseline Fall 2008 = 9%
2012 Target = 12%

Appendix 4

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
Web Site Resources

Action for Healthy Kids www.actionforhealthykids.org/index.htm

Alliance for a Healthier Generation (AHG) http://www.healthiergeneration.org

Centers for Disease Control and Prevention (CDC) www.cdc.gov/nccdphp/dash/index.htm and www.cdc.gov/healthyyouth

The School Health Index for Physical Activity and Healthy Eating: Self-Assessment and Planning Guide: Middle/High School (2005) www.cdc.gov/nccdphp/dash/SHI/index.htm

Guidelines for School Health Programs to Promote Lifelong Healthy Eating
www.cdc.gov/nccdphp/dash/publications/index.htm#guidelines

Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People www.cdc.gov/mmwr/preview/mmwrhtml/00046823.htm and
Physical Activity Guidelines – October 7, 2008 www.health.gov/paguidelines

Promoting Better Health for Young People Through Physical Activity and Sports
www.cdc.gov/nccdphp/dash/physicalactivity/promoting health/index.htm

Promoting Physical Activity: A Guide for Community Action
www.cdc.gov/nccdphp/dnpa/pahand.htm

Effective Population Level Strategies to Promote Physical Activity
www.cdc.gov/nccdphp/dnpa/physical/recommendations.htm

Planet Health (6^{th} - 8^{th} grade students), supplier: Human Kinetics
www.onlinesports.com/pages/I,HK-0-73603-105-7.html

Kidnetic www.kidnetic.com
International Food Information Council (IFIC), Activate, an educational outreach program for ages 9-12. (Has leaders guide component to help you evaluate the impact of kidnetic.com modules)

National Association of State Boards of Education
Fit, Healthy and Ready to Learn - A School Health Policy Guide; Part I: General School Health Policies, Physical Activity, Healthy Eating, and Tobacco -Use Prevention (2002)
www.nasbe.org/HealthySchools/fithealthy.mgi

USDA www.fns.usda.gov
The Power of Choice - Helping Youth Make Healthy Eating and Fitness Decisions - A leader's Guide (ages 11-13)

Changing the Scene: Improving the School Nutrition Environment
www.fns.usda.gov/tn/healthy/index.htm

Appendix 5

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
Scoring Criteria and Points

Applicant Agency			
Reviewer	**Team Review Date**	**Total Score**	
		Possible Points	**Assessed Points**
Section 1 – School District Partner's Assessment of Need (up to 19 points) The ability of each of the applicant's school district partners to identify and describe the data indicators (characteristics) of their student population using referenced and current (within 3 years) data sources that describe:			
Demographics: school size; gender composition; racial/ethnic background		**1**	
Social/Economic: district factor group (DFG) of the district; percentage of students eligible for free and reduced school lunch		**1**	
Performance Achievement: Number (#) and Type of Conduct Referrals; # and Reasons for In- and Out-of School Suspensions; # and Reasons for Detentions; # Unexcused Absences; Rate of Average Daily Attendance; Tardiness; Truancy*; Juvenile Arrests; # Graduates; # Dropouts; # Failures; # Retentions (Seven data indicators selected)		**7**	
Mental Health Needs/priorities: Documentation by school nurse or student assistance counselor (SAC) of depression; stress; grief; issues of physical abuse, violence or anger issues; weapon(s) possession, teasing, harassment or bullying incidents (in person or internet); use or abuse of alcohol, tobacco, other drugs (ATOD); self-esteem issues; distorted body image and eating disorders; suicide ideation or self-injury; mental health referrals made		**3**	
Physical Health Needs/priorities: Weight status using BMI percentiles and/or fitness levels of student population as measured by standardized method or tool; students diagnosed with asthma, diabetes, high blood pressure or cholesterol; hours watched of TV, internet and video games; dietary behaviors; sexual behaviors		**3**	
Resource Directory of youth-serving health and social service agencies		**4**	
*Truancy: 10 or more cumulative unexcused absences, as the term "unexcused absence" is defined by the district board of education, pursuant to N.J.A.C. 6A: 16-7.8(a)3, consistent with the definition of a school day, pursuant to N.J.A.C. 6A:32-8.3.			

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
Scoring Criteria and Points

Applicant Agency			
Reviewer	**Team Review Date**	**Total Score**	
		Possible Points	**Assessed Points**
Section 2 – School Health Action Plan (SHAP) (Goals, Objectives, Methods (Activities), Evaluation) **(18 points)**			
Objectives are identified for each goal and are measurable		**6**	
Proposed SHAP includes all required grant activities and criteria		**10**	
Hire of the SH Specialists within 60 days of July 1 is planned and realistic; Meeting between the SH Specialists and School District Partner's SH Coordinator within 1 month of SH Specialists hire is planned and realistic		**2**	
Section 3 – Budget and Justification **(15 points)**			
Applicant agency submitted a reasonable and appropriate line item budget and justification; included only allowable costs for accomplishing grant objectives and requirements.		**5**	
Commitment to this application is evident from the resource contributions identified on page 6 "Program Income From Other Sources…" by the: 1. Applicant agency = $ 2. School district partners = $ 3. Community partners = $ Total $ commitment (1+2+3) = $			
% Total Contributions = Total $ Commitment / Budget Amount Requested from State Percent (%) — Points ≤2% — 2 2.1 – 4.0 — 4 4.1 - 5.5 — 6 5.6 - 6-9 — 8 ≥ 7.0 — 10		**2-10**	

Appendix 5

BUILDING A STATE-WIDE INFRASTRUCTURE TO SUSTAIN A COORDINATED SCHOOL HEALTH SYSTEM IN NEW JERSEY
Scoring Criteria and Points

Applicant Agency			
Reviewer	**Team Meeting Date**	**Total Score**	
		Possible Points	**Assessed Points**
Section 4 - Applicant Capacity & Collaboration (5 page limit) (18 points) The Applicant's narrative describes leadership experience, accomplishments and commitment specific to:			
Supervision of the SH Specialists delineated in the Applicant's organization chart		**1**	
Collaborative activities that describe experience related to planning, promoting and implementation of joint projects with schools and community partners		**4**	
Establishing and sustaining partnerships with schools and community organizations		**5**	
Identifying and evaluating outcomes that support the efficacy of project efforts		**6**	
Eight or more schools are identified for the CSH pilot project; at least one has a disparate population		**2**	
Section 5 – School District Capacity, & Collaboration (4 page limit/district) (15 points)			
LOS's from the school district Superintendent and the school building Principals are submitted and signed, contributions identified and a dollar value assigned		**2**	
There is a direct line of supervision from the Superintendents office to the SH Coordinator in the school district's organization chart		**3**	
Using CDC's eight component model, the School District Partner's narrative describes the activities, practices and/or policies currently in place that indicates their readiness for CSH planning and implementation		**8**	
Board of Education (BOE) approved School Nutrition/Wellness Policy (1 per district)		**2**	
Section 6 – Community Collaboration (15 points)			
Number of Partners: ≤ 2		**3**	
3		**5**	
4		**8**	
5		**11**	
6 or more		**15**	
TOTAL		**100**	

Appendix 6

COORDINATED SCHOOL HEALTH
Grantee Responsibilities and Activities

The grantee is responsible for the administrative oversight, training, technical assistance and resource support for the implementation of Coordinated School Health activities in school districts located in a Northern, Central or Southern New Jersey region. The School Health Specialists at the grantee agency will collaborate with the School Health Coordinator at the school district to ensure the implementation of required school health activities and ensure they align with State goals and objectives.

Qualifications of Key Personnel – School Health Specialist

- a minimum of a bachelor's degree in public health, health or physical education, health sciences, nutrition, social work, or other related field from an accredited college or university

- five years or more of experience in school health, public health, social service/ health agency or in a youth environment coordinating the implementation of programs for students, staff or the community. Two years should be in an administrative or consultant capacity. A master's degree substitutes for two years of experience

- knowledge of the school environment and experience in working with educators and school administrators

- working collaboratively on community projects and programs with familiarity of county and/or community resources

Activities/Responsibilities

1) Planning of educational trainings and providing technical assistance, guidance and resource support on-site and through email or telephone.

2) Purchasing the District SQL Server Version for the School District Partners. This version requires an SQL Server with LAN/WAN connectivity. Site licenses for each participating school site is also required. **Fitnessgram software should be purchased in advance of the start of the 2010-11 school year.**

3) Facilitating one adult focus group during the 2010-11school year.

4) Ensuring that the SH Coordinator completes required grant activities at their respective schools.

5) Participate in statewide CSH Stakeholders meetings and DHSS training and technical assistance offerings.

6) Mobilizing community resources and identifying new, additional funding source(s) to support and sustain project activities (year 2 and beyond).

7) Creating public awareness of CSH activities and accomplishments through various media, e.g. print, radio, local cable and television (year 2 and beyond).

8) Developing and submitting a School Health Action Plan (SHAP) in collaboration with the school district partners using Attachment 2.

Appendix 7

COORDINATED SCHOOL HEALTH
School District Partner Responsibilities and Activities

1) Identifying a School Health Coordinator; Establishing and maintaining a School Health Team, with representation as required by the CSH SLIM. The SH Team will initially meet to complete the SHI. Areas for improvement will be prioritized and a school health action plan (SHAP) developed with at least two identified programs or actions implemented per grant year. Thereafter, the SH Team will meet no less than twice during the school year to review and revise the SHAP, as needed.

2) Conducting pre- and post-tests using the Fitnessgram and reporting the data to the SH Specialist for inclusion in the DHSS quarterly progress report, the SH Coordinator and the SH Team.

3) Recruiting students by December 31, 2010 to participate in a Youth Advisory Council (YAC). YAC will meet twice and assist the SH Coordinator in conducting one youth focus group before the grant year ends on June 30, 2011. Results will be reported to the CSH Team, the SH Coordinator and the SH Specialists for inclusion in quarterly grant progress reports.

4) Recruiting parents, school staff and other adults and arranging meeting logistics for the SH Specialist to conduct an adult focus group before the end of the grant year. Results will be reported to the SH Team, the SH Coordinator and the SH Specialist for inclusion in quarterly grant progress reports.

5) Planning with the SH Specialists to ensure the participation of the school district partner's schools School Health Profiles Survey conducted by the DOE.

6) Planning for at least one educational session for school staff, parents or the greater school community stakeholders before the end of the grant year.

7) Maintaining agendas, attendance and minutes of meetings in a file at a designated location in the participating school that is available for DHSS review.

8) Maintaining communication with the SH Specialist on a regular basis using email, phone calls and face-to-face meetings to discuss progress, barriers and completion of activities.

9) Contributing input from the SH Team, in consultation with school administration, to the SH Specialist on leveraging funding sources or identifying new, additional funding sources.

10) Promoting CSH activities and accomplishments with students, families and school staff during project years two and three.

11) Assisting SH Specialist in creating public awareness of CSH by providing activities and accomplishments for use in various media, e.g. print, radio, local cable and television in project years two and three.

12) Providing the applicant agency with the school required data submitted with the initial application, at the end of the year three project period.

13) Reviewing annually and updating, as needed, the Resource Directory – Youth Serving Agencies.

Appendix 8

COORDINATED SCHOOL HEALTH Data Sources			
Source	**What the Source Describes**	**Content**	**Examples of Findings**
County Health Improvement Plans (CHIPs)	Health Assessment; Public Health Priority Issues and Strategies/Interventions or Content	▪ Countywide strategies and interventions	▪ County strategies and activities
District Factor Groups (DFGs)	Many of the risk factors described in Morbidity and Mortality Weekly Report (MMWR) are used in NJDOE'S District Factor Groups for the purpose of comparing students' performance on statewide assessments across demographically similar school districts. The categories are updated every ten years. The DFGs represent an approximate measure of a community's relative socioeconomic status (SES).	▪ Districts and District Factor Group classifications	▪ Findings of outcomes grouped by DFG show if our impact varies by socio-economic status (SES)
Fall Survey – Free and Reduced Lunch Program	Student enrollment by school	▪ Total enrollment ▪ Free lunch count ▪ Reduced lunch count	Number of students eligible for free and reduced lunch which is an indicator of family income
Health and Physical Education Survey – New Jersey DOE	Practices and curriculum in grades K-12 in the areas of health education and physical education	▪ Percentage of instructional time spent on 2004 Core Curriculum Content Standards by grade level and by standard ▪ Instructional time spent on physical education activity and health education subject areas ▪ Technology and materials used in physical and health education classes ▪ Professional development provided for physical and health education ▪ Percentage of schools using fitness testing and	▪ Percent of schools aligned with NJ Core Curriculum Content Standards in Comprehensive Physical Education ▪ Types of skills emphasized in physical education class ▪ Types of instructional tools used ▪ Level and types of professional development provided ▪ Fitness testing frequency and types

		what types ▪ Components of grading/assessment of physical and health education	
Kids Count	Population data about age, gender, households, families, and housing units from the Census Short Form and social, economic, and housing data from the Census Long Form as well as regional profiles	▪ Income and poverty ▪ Parental employment ▪ Education ▪ Language ▪ Disability ▪ Neighborhood characteristics ▪ Age and Sex ▪ Race ▪ Hispanic Origin Status ▪ Living arrangements	▪ More expansive than census data ▪ Useful for comparisons by subgroups and to identify counties ▪ Data for 21 counties, 13 108th congressional districts, 4 cities, 11 metropolitan areas, 2 American Indian/Alaska Native/Hawaiian Home Lands, 40 State legislative districts, upper chamber, 40 State legislative districts, lower chamber
National Health Education Standards (NHES)	8 health standards in the areas of community health, consumer health, environmental health, family life, mental/emotional health, injury prevention/safety, nutrition, personal health, prevention/control of disease, substance use/abuse	▪ Standards and performance indicators ▪ Characteristics of effective health education curricula ▪ Health education access and equity principles ▪ Steps for implementing NHES ▪ Assessment guidance	▪ Framework for aligning curriculum, instruction, and assessment practices
New Jersey Core Curriculum Content Standards	The standards describe what students should know and be able to do upon completion of a thirteen-year public education. Revised every five years, the standards provide local school districts with clear and specific benchmarks for student achievement in nine content areas.	▪ Comprehensive Health and Physical Education standards; includes a variety of topics related to PANT/CSH such as: – Wellness – Nutrition – Social and emotional development – Alcohol, tobacco and other drugs	▪ Foundation for creating local curricula and meaningful assessments ▪ Recently enacted legislation outlined in the section below ▪ An emphasis on health literacy, a 21st century theme ▪ Global perspectives about health and wellness through comparative analysis of

		– Fitness and physical activity – Safety – Health services and information ▪ The vision for this section of the Standards is: Knowledge of health and physical education concepts and skills empowers students to assume lifelong responsibility to develop physical, social, and emotional wellness.	health-related issues, attitudes, and behaviors in other countries ▪ Inclusion of additional skills related to traffic safety, fire safety, and accident and poison prevention ▪ Increased awareness of and sensitivity to the challenges related to individuals with disabilities
New Jersey Middle School Risk and Protective Factor Survey	Risk and protective factors among NJ youth as reported by youth	▪ ATOD use ▪ Antisocial behavior ▪ Gambling ▪ Risk and protective factors	▪ Lifetime, annual and past 30 day use of ATOD ▪ Getting suspended in past year ▪ Belonging to a gang ▪ Being arrested ▪ Low neighborhood attachment ▪ Poor family management ▪ Low commitment to school ▪ Prosocial behavior
New Jersey Obesity Action Plan	A plan developed by New Jersey Obesity Prevention Task Force	▪ Specific actionable measures to support and enhance obesity prevention among residents of NJ, with particular attention towards children and adolescents	▪ NJ spent $2.3 billion in 2003 for medical expenses in treatment of obesity-related diseases ▪ In-patient & out-patient costs rising due to obesity ▪ More than half of NJ residents are overweight or obese NJ has the highest incidence of obesity in low-income children aged 2-5 years in the nation
New Jersey Youth	Current patterns of tobacco use among NJ youth	▪ Data on tobacco use	▪ Lifetime use of tobacco

Tobacco Survey (NJ YTS)		including cigarettes, cigars, smokeless tobacco, bidis or kreteks	▪ Current use of tobacco ▪ Frequent use of cigarettes ▪ Accessing and purchasing cigarettes ▪ Exposure to secondhand smoke ▪ Desire to stop smoking ▪ Racial and gender disparities regarding tobacco use
School Health Profiles	Health policies and activities in secondary schools	▪ School health education requirements and content ▪ Physical education requirements ▪ Asthma management activities ▪ Competitive foods practices and policies Family and community involvement ▪ School health policies	▪ Percent of high schools with physical education requirement ▪ Percent of schools with healthy foods in vending machines Percent of schools with a written policy that protects the rights of students or staff with HIV infection or AIDS
Statewide Weight Status Survey of Sixth Graders in New Jersey during the 2003-2004 School Year	Retrospective survey of 2,393 health records of sixth graders in forty randomly selected public schools of varying socio-economic status	▪ Height and weight to calculate BMI	▪ Percent of youth that were obese or overweight ▪ Percent of youth that were at normal weight ▪ Percent of youth that were underweight
Youth Risk Behavior Survey (New Jersey Student Health Survey - NJSHS)	Health risk behaviors of high school students	▪ ATOD use ▪ Dietary behaviors ▪ Personal safety ▪ Physical activity behaviors ▪ Sexual behaviors ▪ Violence behaviors	▪ Alcohol, tobacco and other drug consumption ▪ Asthma ▪ Dental care ▪ Dietary behaviors ▪ Physical violence and weapons ▪ Trends in physical activity ▪ Vehicle safety ▪ Violence on school property Watching television, using computer, video games

Appendix 9

COORDINATED SCHOOL HEALTH
Writing Measurable Objectives

A **goal** is an outcome-oriented statement of the desired or preferred result; in other words, it is a broad statement of the long-range expected accomplishment - where we want to be or what we want to see as the result of what was done. The goals for this CSH pilot project are to:

1) increase the number of schools implementing CDC's CSH model to improve the physical, emotional and social well-being of their students;

2) increase the number of schools that use environmental or policy change strategies to create opportunities for healthier choices by students and school staff;

3) strengthen and sustain state and school district capacity to support a CSH system through effective leadership, strategic partnerships, funding development and the use of data-driven and best practices or evidence-based programs.

Objectives are clear statements of the specific activities required to achieve the goals, starting from the current status. Objectives tell us how we will know if we have reached the goal. A **measurable objective** offers specific milestones by answering "who, what, when, and where;" and clarifying by how much, how many, or how often.

Element	Outcome	Process
When	the time by (or during) which the change in health status, condition or behavior would be achieved	the deadline by which the activity would be accomplished
What	the health status… to be decreased, increased or maintained	the activity to be accomplished
Whom	the population who will benefit from the change in health status	the population who will benefit from the activity
Where	the location of the population	the location of the population
How much, how many or how often	the quantity of change expected in health status … (from current to expected status)	the amount of activity to be utilized, performed or accomplished